UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Zulresso (brexanolone)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

All information to be legible, complete and correct or the request may be denied. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval (all criteria required and documented in submitted chart notes)

- ❑ Medication prescribed by or in consultation with psychiatrist or mental health professional
- ❑ 18 years of age or older
- ❑ Not currently pregnant
- ❑ Less than 6 months post-partum
  Delivery date: _____
- ❑ Moderate to severe postpartum depression with onset of symptoms was in the third trimester or within 4 weeks of delivery confirmed by DSM-V criteria documented in chart notes (must meet one of the following criteria):
  - ❑ Moderate postpartum depression:
    Trial or failure of 6-8 weeks of at least two oral antidepressants at the maximum tolerated dose
    Medication: _____
    Details of treatment / failure: _____
    Medication: _____
    Details of treatment / failure: _____
  - ❑ Severe depression that requires immediate need of medication, provide details in chart note:
    Page:_____
- ❑ No active psychosis, history of seizure, schizophrenia, bipolar, or schizo affective disorder
- ❑ No active untreated substance abuse disorder
- ❑ Plan of depression treatment, including psychotherapy, post Zulresso infusion provided in chart note
  Page: _____
- ❑ Administered at Zulresso REMS certified healthcare facility

Authorization: one (1) infusion per delivery

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date